PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES	***************************************		OMB NO. 0938-03
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING		08/23/2018
	F PROVIDER OR SUPPLIER UNITY MULTI-SERVICE	:s		REET ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTIC
W 000	INITIAL COMMENT	-s	W 000		
	08/22/18 through 08 selected from a pop- various degrees of i survey was conduct fundamental survey  The findings of the sobservations, intervi- administrative reconstructions.  Note: The below are appear throughout the	survey were based on ews and review of client and ds. e abbreviations that may ne body of this report.			
W 192	DSP - Direct Suppo QIDP - Qualified Inte Professional STAFF TRAINING P CFR(s); 483.430(e)(	ellectual Disabilities ROGRAM	W 192		
ı	For employees who must focus on skills toward clients' health	work with clients, training and competencies directed needs.			
,	Based on observation review, the facility fail was trained effective feeding protocol, for the same of	not met as evidenced by: ons, interview and record fied to ensure that each staff y to implement each client's the one (1) of two (2) clients th a modified diet. (Client			
	Findings included:	,	ė		
		AM, observations showed missing upper and lower		- V	
DRATORY	DIRECTOR'S OR PROVIDER	NSOPPLIER REPRESENTATIVE'S SIGN		TITLE	(X6) DATE
Jul	muncell.	ice /	logram	Niceston	9/11/18

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CBK211

Facility ID: 09G255

If continuation sheet Page 1 of 2

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING_	The state of the s	08/23/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/25/2015
COMML	INITY MULTI-SERVICE			WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
W 192	Continued From page	qe 1	W 192		
	with peanut butter, a milk and a cup of or observation showed toast with peanut but Further observations coughed twice while butter.  On 08/23/18, one (1 queried about Client that Client #2 should throughout the meal DSP#2 then offered	the client eating bite-size tter without any liquids. Is showed that the resident eating the toast with peanut minute later DSP #2 was #2's coughing, DSP #2 said		DSP#2 will be retrained on Client meal time protocol. QIDP will commonitor meals.	
	On 08/23/18, at 2:05	PM, the QIDP said that all d on Client #2's feeding			
	feeding protocol date resident should alterr	PM, review of Client #2's d 04/26/18 showed that the nate solids and liquids to facilitate swallowing.			
į	in-service training rec	PM, review of the facility's ords showed all staff elved training on Client #2's 11/20/17.			
. i	ensure all staff was er	rey, the facility failed to fectively trained to mealtime protocol, as	9		

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING		08/23/2018
NAME OF	PROVIDER OR SUPPLIER		· 1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/23/2010
сомми	INITY MULTI-SERVICE	s		WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
E 000	Initial Comments		E 00	0	
	An emergency prep conducted from 08/2	aredness survey was 22/18 through 08/23/18.			
1	The findings of the sobservations, interview emergency prepared	urvey were based on ews and review of the dness program.			
	Note: The below are appear throughout the	e abbreviations that may ne body of this report.			
	EP - Emergency Plan EPP -Emergency Pro QIDP - Qualified Inte Professional RN - Registered Nurs	eparedness Plan llectual Disabilities se			
E 006	Plan Based on All Ha CFR(s): 483.475(a)(1	zards Risk Assessment 1)-(2)	E 006	3	
	and maintain an eme	The [facility] must develop rgency preparedness plan d, and updated at least ust do the following:]			
1	facility-based and cor	include a documented, nmunity-based risk an all-hazards approach.*			
(	on and include a docu community-based risk	§483.73(a)(1):] (1) Be based imented, facility-based and assessment, utilizing an including missing residents.			
ā	and include a docume community-based risk	.475(a)(1):] (1) Be based on inted, facility-based and assessment, utilizing an including missing clients.			

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S, SIGNATURE

Event ID: CBK211

Facility ID: 09G255

If continuation sheet Page 1 of 9

(X6) DATE

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				RM APPROVE O. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		09G255	B WING_	41		8/23/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	0/23/2010
COMMU	NITY MULTI-SERVICE	<b>S</b>		WASHINGTON, DC 20017	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 006	Continued From pa	ge 1	E 00	6		
	(2) Include strategi	es for addressing emergency the risk assessment.	£ 00	o .		
	* [For Hospices at §	418.113(a)(2):] (2) Include ssing emergency events				
	identified by the risk	assessment, including the				
:	failures, natural disa	consequences of power asters, and other emergencies				
,	that would affect the care.	hospice's ability to provide				
	This STANDARD is	not met as evidenced by:				
ſ	review, the facility fa	on, interview and record iiled to develop an all-hazard				
	facility-based and co assessment to ident	ify potential hazards (Gas				
	Leak) essential to th	e facility's geographic of 4 clients residing in the				
1	facility (Clients #1, 2,	, 3 and 4).				
	Findings included.					
	On 08/22/18, at 3:35	PM, observation of the				
' )	facility's location showas located directly a	wed that a shell gas station across from the facility				
1	approximately one-h	undred feet away or less.				
		ng at 3:46 PM, the QIDP said				
	snowstorms, blizzard	nat the facility had identified ls, flooding, tornado,				
1 <b>t</b>	hunderstorms, hurric	canes, crime, earthquakes, to low hazards for this				
f	acility's location.	to tow flazarus (OF UIIS				
(	On 02/23/18 beginnin	ng at 1:30 PM, review of the				
: Ti	erified the QIDP's in	nent (December 2017) terview that snowstorms,				

blizzards, flooding, tornado, thunderstorms, crime, hurricanes and earthquakes were

assessed to be moderate to low hazards for this

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		E & MEDICAID SERVICES	-		OMB NO. 0938-039
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING		08/23/2018
NAME OF	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/23/2016
COMMU	UNITY MULTI-SERVICE			WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTING ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D. RE COMPLETION
E 006	Continued From page facility's location.	ge 2	E 00	06	
	with the QIDP regard When asked why garisk assessment give was located directed QIDP responded by that". The QIDP the would be a potential	v-up interview was conducted rding the risk assessments. as leaks were not part of their ven that the shell gas station d across from the facility, the r say, "I did not think about en stated that a gas leak I hazard for this location. The that she would talk with her s concern.	j.	The facility will develop an all-haz facility based and community bas assessment that will identify poter hazards specific to this facility's to to include living across from a gas	ed risk ntial ocation
E 007	develop an all-hazard community-based ris	sk assessment to identify the ecific to their geographic  Population	E 001	7	
	and maintain an eme	i. The [facility] must develop ergency preparedness plan ed, and updated at least nust do the following:]			
ı s	but not limited to, pers services the [facility] if an emergency; and co	lient population, including, rsons at-risk; the type of has the ability to provide in continuity of operations, of authority and succession	• E-0		
† F T	hospice, PACE, HHA, FQHC, or ESRD facili This STANDARD is n	sk" does not apply to: ASC, , CORF, CMCH, RHC, ities.] not met as evidenced by: and record review, the facility			

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		AND HUMAN SERVICES			FORM APPROVE
CENTERS FO	JR MEDICARE	& MEDICAID SERVICES	r		OMB NO. 0938-03
AND PLAN OF COR	WE CONTROLLED IN TOENTIFICATION WINNESS.		(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING_	The second secon	08/23/2018
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/20 (8
COMMUNITY	IULTI-SERVICE	:s		WASHINGTON, DC 20017	
(X4) ID PREFIX ( TAG R	EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	nued From pa		E 00		
assur for for (Clien	ne the leaders ur (4) of 4 clier its #1, 2, 3 and	Pidentified which staff would hip role during an emergency, this residing in the facility 4).		The facility's EP will identify a sta for each shift that will assume the role if the management cannot be during an emergency. QIDP will necessary training for the staff m	e leadership e contacted provide
Findir	igs included:			assigned to each shift.	9/21/18
At 4:00 QIDP leader stated memb leaders	be responsible an emergence of PM, an intended regarding staff ship roles during that there was er responsible ship role during	view was conducted with the assuming specific assuming specific as an emergency. The QIDP is no written authorized staff on each shift to assume the gan emergency.			
ensure would a and ad emerge E 015 Subsis	that the EP id assume the lea ministrator cou ency.	vey, the facility failed to entified which staff member adership role if the QIDP, RN ald not be reached during an or Staff and Patients	E 015		
develop policies plan se assessi and the this sec reviewe minimur	and impleme and procedure t forth in paragment at paragr communication. The polic d and updated	edures. [Facilities] must nt emergency preparedness es, based on the emergency raph (a) of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be at least annually.] At a and procedures must			

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			
STATEMENT	OF DÉFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G255	B WING_		00/02/0040
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/23/2018
COMMUN	IITY MULTI-SERVICE	ES		WASHINGTON, DC 20017	ODE  OB/23/2018  ODE  RRECTION (X5) SHOULD BE COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 015	Continued From pa	ge 4	E 015	*	
* P(6) hn Tr for sum of sys	and patients whether place, include, but a ci) Food, water, med supplies iii) Alternate sources of the safety and for Inpatient Hospi olicies and procedure.  (D) Sewage and water, may be policies and procedure or shelter in the following: i) The provision of safety and for the provisions. (B) Alternate source lowing: (C) Temperature: (C) Sewage and water.	extinguishing, and alarm vaste disposal.  ce at §418.113(b)(6)(iii):]  res. additional requirements for vatient care facilities only. bedures must address the subsistence needs for and patients, whether they a place, include, but are not g: edical, and pharmaceutical es of energy to maintain the sto protect patient health a safe and sanitary storage ghting.  n, extinguishing, and alarm			
Ba	sed on record revie	ew and interview, the facility			

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		AND HUMAN SERVICES		·	FORM APPROVE
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
) // 		09G255	B WING_		08/23/2018
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2010
СОММ	UNITY MULTI-SERVICE	S		WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 015	to ensure adequate necessary to mainta emergency situation	ge 5  Itten policies and procedures alternate energy sources iin temperatures during is, for four (4) of 4 clients y (Clients #1, 2, 3 and 4).	E 01	The facility's EP Plan will be updat include Policy and Procedures tha address what to do in the event of control failure during an emergenc QIDP will train staff on policy.	t will temperature
E 024	facility's EP dated Die evidence that policie developed to maintal emergencies.  During an interview of QIDP confirmed that procedures specifical during emergencies.  At the time of the surthat the facility developed that addressed temporand safety and sanital emergency situations. Policies/Procedures-CFR(s): 483.475(b)(6)  [(b) Policies and procedure plan set forth in paragrand the communication this section. The policies reviewed and updated	vey, there was no evidence oped policies and procedures erature to protect the health ary provisions during volunteers and Staffing volunteers and Staffing edures. The [facilities] must emergency preparedness es, based on the emergency praph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be a teast annually. At a and procedures must	E 024		

		( )		)	
		AND HUMAN SERVICES			PRINTED: 09/05/201 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIFLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		09G255	B. WING		08/23/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
СОММС	JNITY MULTI-SERVICE			WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
E 024	Continued From pag	ge 6	E 02	24	
	(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			The facility's Policy & Procedupdated to address the used during emergency situations Programs will be contacted fassistance.	of volunteers . Citizen Corp
;	procedures. (6) The emergency and other strategies to address emergency. This STANDARD is Based on record rev	s surge needs during an not met as evidenced by: riew and interview, the facility cies and procedures that			

Findings included:

facility. (Clients #1, 2, 3 and 4)

On 08/23/18, at 12:59 PM, review of the facility's EP, dated December 2017 showed no evidence that policies and procedures had been developed to address how and if the facility would use volunteers during emergencies.

emergency, for four (4) of 4 clients residing in the

On 08/23/18, at 3:45 PM, the QIDP said during an interview that the facility would not use volunteers during emergency situations. When asked if there were policies and procedures related to volunteers in the EPP, the QIDP responded by saying, "no".

At the time of the survey, there was no evidence that the facility's EP addressed the use of volunteers during emergencies.

E 035 LTC and ICF/IID Sharing Plan with Patients

E 035

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		AND HUMAN SERVICES  8 MEDICAID SERVICES			FOR	RM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) C	NO. 0938-03 DATE SURVEY COMPLETED	
		09G255	B. WING	- III		08/23/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		MILWING I
COMMU	UNITY MULTI-SERVICE	:S		WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
E 035	Continued From pa	ge 7	E 03	15		
	CFR(s): 483.475(c)	_	E 03	10		
	and maintain an em communication plan State and local laws updated at least and plan must include al (8) A method for sha emergency plan, that is appropriate, with or families or represent This STANDARD is Based on record revisited to ensure each representative had be regarding the facility' (4) of 4 clients residing 2, 3 and 4).	aring information from the at the facility has determined residents [or clients] and their				
,	Findings included:					
ŀ	facility's EP communi	ing at 1:30 PM, review of the ication plan dated December mary and alternate means for family members and elephone and e-mails.				
1 - 1 - 6 - 6 - 7	that she had not conto members and/or guar e-mail regarding the f QIDP stated that she	P said during an interview acted the clients' family rdians via telephone or facility's EP information. The would e-mail the clients' guardians the facility's EPP a chance to do so.		QIDP notified family members guardians via email, regard EP information.		9/6/18

At the time of the survey, the facility failed to ensure the clients' family members and/or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	09G255	B, WING		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/23/2018
COMMUNITY MULTI-SERVIC		i	WASHINGTON, DC 20017	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
E 035 Continued From paguardians were ma once the plan had I	ide aware of the facility's EPP	E 035	The facility developed a written puthe EPP that contains methods were Communication Plan that will give for sharing information with the Communication processes and the Communication processes are contained as a second processes and the Communication processes are contained as a second processes are contained as a se	within the re guidance Clients'

ing Administration				
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HFD03-2888	B WING		08/23/2018	
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ES WASHIN	CTON DC 20	047		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE	
TS	1 000			
was conducted from 08/22/18 A sample of two residents was culation of four females with intellectual disabilities, survey were based on riews, and reviews of resident records.  The abbreviations that may he body of this report.  The Professional of the for Individuals with esemble conductions in the semble conductions in the semble conduction of the semble conduction of the semble conduction of the semble conduction of two conductions are conducted in the semble conducted from the				
RVICE / DINING AREAS	1 042			
oe as follows:				
ed, and served by individuals nstruction from a dietitian;				
net as evidenced by: ns, interview and record led to ensure that each staff ly to implement each client's the one (1) of two (2) sample with a modified diet.				
AM, observations showed missing upper and lower				
	HFD03-2888  STREET A  WASHIN  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  TS  Was conducted from 08/22/18 A sample of two residents was pulation of four females with intellectual disabilities. Survey were based on liews, and reviews of resident ecords.  The Professional efor Individuals with essellectual Disabilities  RVICE / DINING AREAS  The as follows:  Individuals with essellectual Disabilities  RVICE / DINING AREAS  The as evidenced by: The as evi	TES STREET ADDRESS, CITY, S  WASHINGTON, DC 20  ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  WAS conducted from 08/22/18 A sample of two residents was obliation of four females with intellectual disabilities.  Survey were based on iews, and reviews of resident ecords.  The Professional e for Individuals with essellectual Disabilities  RVICE / DINING AREAS 1042  De as follows:  Id, and served by individuals instruction from a dietitian;  Inter as evidenced by: Ins, interview and record led to ensure that each staff y to implement each client's the one (1) of two (2) sample with a modified diet.  AM, observations showed missing upper and lower	DENTIFICATION NUMBER:   A BUILDING:   B WING	

STATE FORM

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Health Regulation & Licensii	ng Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	HFD03-2888	B. WING_		08/23/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	
COMMUNITY MULTI-SERVICES WASHINGTON, DC 20017				
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
peanut butter, a bove and a cup of orange showed the Resider peanut butter without observations showed twice while eating the On 08/23/18, one (1 queried about Residual said that Resident #2 throughout the meal DSP#2 then offered alternate with the toa On 08/23/18, at 2:05 staff had been trained protocol.  On 08/23/18, at 2:15 feeding protocol date resident should alternate with the meal of the survey of	rived bite-size toast with vi of bran flakes with 2% milk in juice. Further observation at eating bite-size toast with any liquids. Further dight that the resident coughed in e toast with peanut butter.  I minute later DSP #2 was ent #2's coughing. DSP #2 2 should take sips of liquids to help prevent choking. The resident orange juice to list and peanut butter.  PM, the QIDP said that all do no Resident #2's feeding  PM, review of Resident #2's do 04/26/18 showed that the late solids and liquids to facilitate swallowing.  PM, review of the facility's lords showed all staff erived training on Resident to on 11/20/17.	1042	DSP #2 will be retrained on Client meal time protocol. QIDP will cont to monitor meals.	
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